Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLLEGE STATION MEDICAL CENTER
3200 SW FRWY SUITE 2200
HOUSTON TX 77027

Respondent Name

EMPLOYERS ASSURANCE CO

Carrier's Austin Representative Box

Box Number 34

MFDR Tracking Number

M4-07-0803-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "College Station Medical Center submitted its UB92 and itemized statement reflecting ICD-9 code 825.1. Pursuant to Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's fair and reasonable and usual and customary charges, which is $229,027.60. AmComp issued an underpayment of $61,344.82 and denying any balance owed on the basis that the claim was reimbursed at a fair and reasonable charge. However, this claim involves trauma and emergency admit, and additional reimbursement of $167,682.78 is due and owing to the hospital."

Amount in Dispute: $167,682.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The above admission is subject to reimbursement pursuant to Rule 134.401(c)(5). Reimbursement for the entire admission was based on a fair, reasonable and consistent methodology neither the per diem method nor the stop loss method applies to this admission." "The methodology used to determine fair and reasonable is based on Center For Medicare Services (CMS) Inpatient DRG allowable for provider 450299 dates of service 12/12-12/29/2005 DRG 253 x 213% (213% of Medicare is fair and reasonable) plus carve outs for CT Scans." "DRG Allowable based on CMS Pricer06 equals $27,792.44. $27,792.44 times 213% equals $59,197.90. Additional reimbursement for the following CT Scan was based on the technical component value established in the Texas Workers Compensation Fee Schedule." "Total Reimbursement equals $61,344.82."

Response Submitted by: UniMed Direct on behalf of AmComp Assurance Corp., 5068 W. Plano Pkwy, Ste. 122, Plano, TX 75093-4453

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2005 through December 29, 2005	Inpatient Services	$167,682.78	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on October 6, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 16, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated August 31, 2006

   - TX W1-Workers Compensation State Fee Schedule Adjustment.
   - W1 (01) – RC 01 The charge for the procedure exceeds the amount indicated in the fee schedule.
   - W1 (RD) – RC RD The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research, and is in accordance with labor code 413.011(b).

   Explanation of Benefits dated September 25, 2006

   - TX W1-Workers Compensation State Fee Schedule Adjustment.
   - W1 (YO) – RC YO Denial After Reconsideration.
   - W1 (YS) – RC YS Supplemental Payment.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 825.1. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Pursuant to Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's fair and reasonable and usual and customary charges, which is $229,027.60. AmComp issued an underpayment of $61,344.82 and denying any balance owed on the basis that the claim was reimbursed at a fair and reasonable charge. However, this claim involves trauma and emergency admit, and additional reimbursement of $167,682.78 is due and owing to the hospital."
   - The requestor did not discuss or explain how it determined that 100% of the amount billed would yield a fair and reasonable reimbursement.

- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/20/2012 Date
Signature	Health Care Business Management Director	1/20/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.